STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445445	A. BUILDING _____ B. WING _____	07/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELINA HEALTH AND REHABILITATION CENTER	120 PITCOCK LANE CELINA, TN 38551

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide a social services admission assessment and discharge planning services for one resident (#61) of twenty-three residents reviewed. The findings included: Resident #61 was admitted to the facility on May 10, 2013, with diagnoses including Aftercare Left Hip Replacement, Atrial Fibrillation, Congestive Heart Failure, Hypertension, Stage III Chronic Kidney Disease, Anemia, and Muscle Weakness. Medical record review of the hospital History and Physical dated March 29, 2013, revealed the resident lived alone, fell at home, and was found by a family member after an unsuccessful attempt to reach the resident by telephone. Medical record review of the Interdisciplinary Departmental Notes dated May 10, 2013 through July 8, 2013, revealed no documentation of a Social Services admission assessment or the initiation of discharge planning for the resident. Interview with the Director of Social Services on	F 250	This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding. F250 1. Resident # 61 was assessed by the Social Services Director on 7/15/13 for any social services needs and discharge planning needs. 2. An audit of the last 90 days admissions was completed by the Administrator to assess for the presence of admission assessments and discharge planning. No other residents were identified as having been affected. 3. The Social Services Director	Completion Date 7/17/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Moore	NHA	7/17/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUL 22 2013

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F 250	Continued From page 1 July 10, 2013, at 11:55 a.m., in the conference room confirmed facility had failed to complete a Social Services admission assessment or initiation or to initiate discharge planning for resident #61.	F 250	was in serviced by the Administrator on 7/15/13 regarding proper assessment and discharge planning for new admissions. 4. The Administrator will audit all new admission assessments for four weeks then fifteen new admissions per month for two months or until 100% compliance is achieved. All results will be reported monthly by the Administrator to the Quality Assurance Performance Improvement committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to document a pain assessment for one resident (#1) and failed to document complete and accurate behavior monitoring for one resident (#19) of twenty-six residents reviewed. The findings included: Resident #1 was admitted to the facility on May 1, 2006, and readmitted October 10, 2012, with diagnoses including Diabetes Mellitus, Vascular Dementia, Psychosis, Depression, Cerebral Palsy, Bell's Palsy, and Chronic Pain related to Osteoarthritis. Medical record review of the Medication Administration Record (MAR) for June 2013 revealed a pain assessment documented on the MAR twice daily. Medical record review of the Pain Assessment Flow Sheet for the month of June 2013 revealed no documentation of a Pain Assessment on the	F 281		

JUL 22 2013

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F 281	Continued From page 2 form. Medical record review of a fax to the Physician dated January 2, 2013, revealed "...is crying with all movements and ADLs (Activities of Daily Living) - is getting Lortab (narcotic pain medication)5/500 milligrams (mg) QID (four times daily) - has started screaming when moved or touch. Would you consider a pain patch?..." and the Physician's response was "...NO..." Medical record review of a Physician's note dated June 30, 2013, revealed "...apparent pain on movement and ADLs - will add Fentanyl (narcotic analgesic) patch & reassess may need increase in Exelon (antidepressant)..." Review of facility policy, Pain Management, revealed "...Pain will be reviewed/scored using a numeric 0-10 scale with 1-3, mild pain, 4-6 moderate pain, 7-10 severe pain..." Interview with Licensed Practical Nurse (LPN #1) on July 10, 2013, at 9:20 a.m., in the nurses' station, confirmed the Pain Assessment Flow Sheet was not completed. Resident #19 was admitted to the facility on May 1, 2006, and readmitted on May 28, 2013, with diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Congestive Heart Failure, Gastroesophageal Reflux Disease, Dementia, Anxiety, Depression, Hypertension, Chronic Renal Failure, Rheumatoid Arthritis, Osteoarthritis, and Osteoporosis. Medical record review ofa Physician's Orders	F 281	F281 1. A pain flow sheet was initiated on 7/11/13 for resident #1 by the Staffing Coordinator. A Behavior Monitoring sheet was initiated on 7/11/13 for Resident # 19 by the Staffing Coordinator. 2. An audit was completed on 7/11/13 of all pain assessment flow sheets and all behavior monitoring sheets by the Staffing Coordinator and QA nurse to insure that the pain flow sheets and behavior monitoring sheets were being implemented. No other residents were identified as having been affected. 3. All licensed nurses were in serviced on 7/10/13 regarding the completion of the Behavior Monitoring sheets and Pain Assessment Flow Sheets by the QA Nurse.	Completion Date 7/17/13

JUL 22 2013

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F 281	Continued From page 3 dated June 4, 2012, revealed an order for Klonopin (anti-anxiety) 0,25 mg daily at bedtime. Medical record review of the Psychoactive Medication Monthly Flow Record for May and June 2013 revealed the Target Behavioral Symptom being monitored was anxiety. Continued review of the record revealed many blank spots on the form where behavior was not documented. Review of facility policy, Behavior Assessment and Monitoring, revealed "...the staff will document ongoing reassessments of changes in the individual's behavior, mood, and function..." Interview with LPN #3 on July 9, 2013, at 3:08 p.m., in the nurses' station, confirmed documentation of target behavioral symptoms was missing on many occasions.	F 281	4. The Director of Nursing will audit fifteen charts per week for four weeks then fifteen charts per month for two months or until 100% compliance is achieved. All results will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329		

JUL 22 2013

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F 329	Continued From page 4 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure medications were administered to residents according to physician's orders for one resident (#1) of twenty-six residents reviewed. The findings included: Resident #1 was admitted to the facility on May 1, 2006, and readmitted October 10, 2012, with diagnoses including Diabetes Mellitus, Vascular Dementia, Psychosis, Depression, Cerebral Palsy, Bell's Palsy, and Chronic Pain related to Osteoarthritis. Medical record review of Physician's Orders dated October 6, 2012, revealed an order for Aspirin 81 milligrams (mg) every third day. Review of the Medication Administration Record for June 2013 revealed the Aspirin was administered every other day for the whole month. Interview with Licensed Practical Nurse #2 on	F329 F 329	1. The Charge Nurse clarified the order for Aspirin 81 mg every third day with the MD on 7/10/13. The physician and the responsible party was notified by the Charge Nurse on 7/10/13 regarding the resident receiving an Aspirin 81 mg every second day in June 2013 rather than every third day per the MD order. 2. An audit of all Medication Administration Records and all Physician Orders was completed on 7/11/13 by the Staffing Coordinator and the QA Nurse. No other residents were identified as having been affected. 3. All Licensed Nurses were in serviced on 7/11/13 by the QA Nurse regarding proper medication administration procedures. 4. The Director of Nursing will audit five charts per week for	Completion Date 7/17/13

JUL 22 2013

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F 329	Continued From page 5 July 10, 2013, at 8:40 a.m., in the nurses' station, confirmed the medication was ordered to be administered every three days and confirmed the medication was administered incorrectly every other day during the month of June 2013.	F 329	four weeks then fifteen times per month for two months or until 100% compliance is achieved. All results will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a sanitary and safe environment related to the storage of food in the three-compartment sink. The findings included: Observation on July 9, 2013, at 11:17 a.m., in the kitchen, revealed one large bowl with fifty-six (56) individual wrapped pieces of cornbread inside the bowl, stored in the sanitizer sink of the three-compartment sink. Continued observation revealed the "eco lab" detergent (used for sanitizing kitchen pans) tubing connected to the detergent with the tubing extended into the three compartment sink where the bowl with the cornbread was stored. Further observation	F 371		

JUL 22 2013

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F 371	Continued From page 6 revealed Kitchen Employee #1 took the bowl from the three compartment sink and placed one piece of corn bread on each residents tray stored on a serving cart. Interview with Kitchen Employee #1, on July 9, 2013, at 11:20 a.m., in the kitchen revealed "...we do not use the three compartment sink unless the dishwasher is not working...moved the bowl with the cornbread into the three compartment sink because there was not enough space to place the employee trays on the counter..." Interview with the Dietary Manager, on July 9, 2013, at 11:21 a.m., in the kitchen confirmed the facility had failed to ensure cornbread was stored in a sanitary and safe environment.	F 371	F371 1. The cornbread was removed by the Dietary Aide from the area close to the chemicals on 7/9/13. 2. An evaluation of the storage of food was completed on 7/15/13 by the Dietary Manager to insure all food was stored in a safe and sanitary procedure. No other residents were identified as having been affected.	Completion Date 7/17/13
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	3. All dietary staff were in serviced on 7/15/13 regarding proper food storage. 4. The Dietary Manager will observe the meal service five times per week for four weeks then fifteen times per month for two months or until 100% compliance is achieved. All results will be reported monthly by the Dietary Manager to the Quality Assurance Performance Improvement committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing	

JUL 22 2013

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F 441	Continued From page 7 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to follow infection control practices during an ice pass for eight of thirty-three rooms on two of two halls observed. The findings included: Observation on July 9, 2013, at 9:20 a.m., on the 200 hall, revealed Certified Nursing Assistant (CNA) #5 entered a resident room to retrieve a resident's ice pitcher. Continued observation revealed the CNA exited the resident's room and opened the ice chest on the hydration cart, held the resident's personal pitcher over the ice chest and filled the pitcher with ice by placing the ice scoop inside the rim of the ice pitcher. Continued observation revealed the CNA then replaced the	F 441	Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.	

JUL 22 2013

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F 441	Continued From page 8 scoop by flipping the plastic scoop cover up with the clean ice scoop. Continued observation revealed the CNA then re-entered the resident's room with the residents ice pitcher and returned with the roommate's ice pitcher and repeated the same procedure. Observation on July 9, 2013, from 9:30 a.m. to 9:40 a.m., revealed CNA #5 filled ice pitchers in four rooms on the 200 hall then proceeded to the 100 hall and filled ice pitchers for four more rooms by holding all the residents personal ice pitchers over the ice chest, placing the ice scoop inside the rim of the pitchers and replacing the ice scoop by flipping the plastic scoop cover up with the clean ice scoop. Interview with CNA #5 on July 9, 2013, at 9:45 a.m., on the 100 hall, confirmed CNA #5 was holding the ice pitcher over the ice chest, placing the ice scoop inside the rim of the pitcher, and replacing the scoop by flipping the plastic cover up with the clean ice scoop and did not follow facility procedures for infection prevention. Interview with Registered Nurse #1 on July 10, 2013, at 11:41 a.m., at the nurse's station, confirmed the facility had failed to follow guidelines to prevent the spread of infection.	F 441	F441 1. The nursing assistant was counseled by the Staffing Coordinator on 7/10/13 regarding the proper procedures for passing ice to residents. All ice chests were audited for cleanliness on 7/10/13 by the Staffing Coordinator. 2. The affected ice was removed and the ice chest was sanitized by the Dietary Department on 7/10/13. All ice chests were audited for cleanliness on 7/10/13 by the Staffing Coordinator. No other residents were identified as having been affected. 3. All Certified Nursing Assistants were in serviced by the Staffing Coordinator on 7/10/13 regarding proper passing of ice to residents. 4. The Director of Nursing will observe the passing of ice to residents five times per week for four weeks then fifteen	Completion Date 7/17/13

JUL 22 2013